Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ACTIVE BEHAVIORAL HEALTH LLC
6300 SAMMUELL BLVD #112
DALLAS TX 75228

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
CONTINENTAL CASUALTY CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-08-2055-01
(previously: M4-03-3755-01)

MFDR Date Received
MARCH 6, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On January 28, 2003 we sent a request for reconsideration to RSKCO, P.O. Box 139046, Dallas, TX 75313-9826, regarding the bills for the claimant… The carrier claim number is #3A806713Y5 and the social security number is xxxx-xx-xxxx. The carrier has failed to provide Reconsideration Explanation of Benefits and/or medical audit summaries within the required 28 day period for dates of 7-1-02 through 9-24-02. Also carrier failed to provide initial EOBs for the dates of 7-1-02 through 9-24-02."

Amount in Dispute: $42,740.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that the carrier has not record of receiving a TWCC-60 relating to the Active Behavioral Health dispute (M4-03-3755-01). If the attached EOB does not correlate to any of the dates of service in dispute, please let me know and we will research further to find a relevant EOB."

Response Submitted by: Wilson Grosenheider & Jocobs LLP, 6836 Austin Center Blvd., Ste. 280, Austin, TX 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2002	CPT Code 90801 – Psychiatric Diagnostic Interview $3/minute x 60	$180.00	$180.00
May 24, 2002	CPT Code 90825 – Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes. $2/minute x 60 minutes	$120.00	$120.00
May 24, 2002	CPT Code 90899 – Preparation of report $2/minute	$240.00	$0.00
July 1, 2002 – September 24, 2002	CPT Code 97799 – Chronic Pain Management	$42,160.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on March 6, 22003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, the Division notified the requestor on March 20, 2003 (under previous MDR tracking number) to send additional documentation relevant to the fee dispute as set forth in the rule.
5. EOBs were not submitted by either party. Review of records, contained in the dispute file, indicates the Carrier denied the treatment/services as not related to the compensable injury.

Findings

1. According to the documentation a benefit review conference was held on September 23, 2002 to mediate resolution of the disputed issues, by the parties were unable to reach an agreement. A benefit contested case hearing was held on November 26, 2002; the decision of the hearing officer was that the compensable injury includes ligamentous instability at C5-C6, but does not include arthritis at C5-C6 or a dessicated disc at C5-C6 or any aggravation of those conditions. The insurance carrier appealed the decision and the Appeals Panel affirmed the decision of the Hearing Officer. The insurance carrier appeal the Appeals Panel decision to the Dallas County District Court; on July 25, 2003 the presiding judge overturned the Appeals Panel decision and decreed that the claimants compensable injury did not include ligamentous instability at C5-6. According to the TWCC-21 filed by the carrier on March 29, 2002 the compensable injury is a cervical strain and abrasions to the right forearm.
2. Review of the medical bills for the services in dispute shows the health care provider used ICD-9 Code 847.0 – Neck Strain as the first diagnosis code in Box 21 of the CMS-1500. Therefore, the disputed dates of service will be reviewed in accordance with Division Rules and the Labor Code in effect at the time the services were rendered.
3. The requestor billed CPT Codes 90801 – Psychiatric diagnostic interview examination including history, mental status, or disposition ($3 per minute); 90825 – Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes ($2 per minute); and 90889 – Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers ($2 per minute). Review of the submitted initial behavioral medicine intake report documents: Review of records (1 hour), Initial Clinical Intake (1 hour), Mental Status Exam, Behavioral Observations, Patient Symptoms Rating Scale, Pain Drawing, and Report Generation (2 hours). The report documents the review of the records (CPT Code 90825) and the psychiatric diagnostic interview (CPT Code 90801) as one hour each. Therefore, in accordance with the 1996 Medical Fee Guideline (II)(G)(3) reimbursement is recommended.
4. The preparation of the report (CPT Code 90889) is included in other services such as a mental status exam, behavioral observations, patient symptoms rating scale and pain drawing; therefore, the amount of time sent in the actual preparation of the report is not separately documented; therefore, reimbursement cannot be recommended.
5. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission.
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

7. 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "a description of the healthcare for which payment is in dispute." Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
8. 28 Texas Administrative Code §133.307(g)(3)(C)(ii), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "the requestor's reasoning for why the disputed fees should be paid." Review of the submitted documentation finds no documentation of the requestor's reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(ii).
9. 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).
10. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
    - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
    - The requestor did not submit documentation to support that $200 per hour for the Chronic Pain Management program is fair and reasonable.
    - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
    - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
    - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
    - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

    Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the Chronic Pain Management; therefore, reimbursement is not supported.

    Review of the report for the CPT Codes 90801 – Psychiatric Diagnostic Interview and 90825 – Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes support reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor for the Chronic Pain Management Program; however, the documentation submitted for CPT Codes 90801 and 90825 support reimbursement. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 30, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	July 30, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.